		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021436

Facility Name: Lewis Memorial Christian Village

Address: 3400 West Washington (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: 217-787-9600 **Fax #** ( )

IDPA ID Number: 51-0173104001

Date of Initial License for Current Owners: 9/77

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark Havrilka

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) William O. Buskirk CPA

(Firm Name & Address) Eck, Schafer & Punke, LLP
600 East Adams Springfield, IL 62701-1624

(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3	79	Intermediate (ICF)	79	28,914	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,776	14,732		26,508	8
9	SNF/PED					9
10	ICF	11,724	15,295		27,019	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,500	30,027		53,527	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.35%

D. How many bed-hold days during this year were paid by Public Aid? 78 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/19/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary None

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	225,217	27,753	19,108	272,078		272,078		272,078			1
2	Food Purchase		252,049		252,049		252,049	(633)	251,416			2
3	Housekeeping	137,769	21,202	284	159,255		159,255		159,255			3
4	Laundry	71,461	19,452		90,913		90,913		90,913			4
5	Heat and Other Utilities			110,185	110,185		110,185	71	110,256			5
6	Maintenance	72,640	17,747	55,578	145,965		145,965	8,042	154,007			6
7	Other (specify):*											7
8	**TOTAL General Services**	507,087	338,203	185,155	1,030,445		1,030,445	7,480	1,037,925			8
	B. Health Care and Programs											
9	Medical Director			320	320		320		320			9
10	Nursing and Medical Records	1,915,931	99,012	13,499	2,028,442		2,028,442		2,028,442			10
10a	Therapy			7,755	7,755		7,755		7,755			10a
11	Activities	30,694			30,694		30,694	(900)	29,794			11
12	Social Services	84,494	4,172	4,001	92,667		92,667		92,667			12
13	Nurse Aide Training											13
14	Program Transportation		174		174		174		174			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,031,119	103,358	25,575	2,160,052		2,160,052	(900)	2,159,152			16
	C. General Administration											
17	Administrative	96,104	2,415	214,236	312,755		312,755	(173,902)	138,853			17
18	Directors Fees											18
19	Professional Services			6,920	6,920		6,920	22,850	29,770			19
20	Dues, Fees, Subscriptions & Promotions			10,241	10,241		10,241	672	10,913			20
21	Clerical & General Office Expenses	100,684		60,820	161,504		161,504	23,658	185,162			21
22	Employee Benefits & Payroll Taxes			385,283	385,283		385,283	(2,793)	382,490			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,843	3,843		3,843	3,075	6,918			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,646	26,646		26,646	1,688	28,334			26
27	Other (specify):*											27
28	**TOTAL General Administration**	196,788	2,415	707,989	907,192		907,192	(124,752)	782,440			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,734,994	443,976	918,719	4,097,689		4,097,689	(118,172)	3,979,517			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lewis Memorial Christian Village #0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			176,721	176,721		176,721	12,756	189,477			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			245,808	245,808		245,808	(143,995)	101,813			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			98	98		98		98			35
36	Other (specify):* **Financing Fees**			5,852	5,852		5,852		5,852			36
37	**TOTAL Ownership**			428,479	428,479		428,479	(131,239)	297,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,651	1,651		1,651		1,651			39
40	Barber and Beauty Shops	29,697	1,960		31,657		31,657		31,657			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,212	87,212		87,212		87,212			42
43	Other (specify):* **Apt/Congregate**			770,368	770,368		770,368		770,368			43
44	**TOTAL Special Cost Centers**	29,697	1,960	859,231	890,888		890,888		890,888			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,764,691	445,936	2,206,429	5,417,056		5,417,056	(249,411)	5,167,645			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(633)	2		4
5	Telephone, TV & Radio in Resident Rooms	(760)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,523	30		9
10	Interest and Other Investment Income	(91,135)	32		10
11	Discounts, Allowances, Rebates & Refunds	(242)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(52,860)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,829)	21		24
25	Fund Raising, Advertising and Promotional	(534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,621)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (151,091)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(98,320)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (98,320)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (249,411)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Revenue	$ (1,721)	17	1
2	Activity Revenue	(900)	11	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(2,621)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(633)	0	0	0	0	0	0	0	0	0	0	(633)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(760)	831	0	0	0	0	0	0	0	0	0	71	5
6	Maintenance	0	8,042	0	0	0	0	0	0	0	0	0	8,042	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,393)	8,873	0	0	0	0	0	0	0	0	0	7,480	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(900)	0	0	0	0	0	0	0	0	0	0	(900)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(900)	0	0	0	0	0	0	0	0	0	0	(900)	16
	C. General Administration													
17	Administrative	(1,721)	(172,181)	0	0	0	0	0	0	0	0	0	(173,902)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,850	0	0	0	0	0	0	0	0	0	22,850	19
20	Fees, Subscriptions & Promotions	(534)	1,206	0	0	0	0	0	0	0	0	0	672	20
21	Clerical & General Office Expenses	(6,071)	29,729	0	0	0	0	0	0	0	0	0	23,658	21
22	Employee Benefits & Payroll Taxes	0	(2,793)	0	0	0	0	0	0	0	0	0	(2,793)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,075	0	0	0	0	0	0	0	0	0	3,075	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,688	0	0	0	0	0	0	0	0	0	1,688	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,326)	(116,426)	0	0	0	0	0	0	0	0	0	(124,752)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,619)	(107,553)	0	0	0	0	0	0	0	0	0	(118,172)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lewis Memorial Christian Village **#** 0021436 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,523	9,233	0	0	0	0	0	0	0	0	0	12,756	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(143,995)	0	0	0	0	0	0	0	0	0	0	(143,995)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(140,472)	9,233	0	0	0	0	0	0	0	0	0	(131,239)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(151,091)	(98,320)	0	0	0	0	0	0	0	0	0	(249,411)	45

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$		100.00%	$ 831	$ 831	1
2	V	6	Maintenance				8,042	8,042	2
3	V	17	Administrative	214,236			42,055	(172,181)	3
4	V	18	Directors						4
5	V	19	Professional Services				22,850	22,850	5
6	V	20	Fees/Subscriptions/Promotion				1,206	1,206	6
7	V	21	Clerical				29,729	29,729	7
8	V	22	Employee Benefits	16,380			13,587	(2,793)	8
9	V	23	In-Service						9
10	V	24	Travel and Seminar				3,075	3,075	10
11	V	26	Insurance				1,688	1,688	11
12	V		Human Resources						12
13	V	30	Depreciation				9,233	9,233	13
14	Total			$ 230,616			$ 132,296	$ * (98,320)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This worksheet is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Reilly Mortgage		x	Bldg. & Equip.	$16,828.00	05/01/76	$ 2,557,200	$ 2,004,541	09/01/18	0.0750	$ 152,094	1
2	Revenue Bonds 1991-C	x		Redeem Debt	$6,082.00	07/01/91	742,000	570,598	07/01/11	0.0775	40,854	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$22,910.00		$ 3,299,200	$ 2,575,139			$ 192,948	9
	B. Non-Facility Related*											
10	Tax Exempt Bonds		x	Building Congregate		11/15/96	980,000	91,667	11/15/00	0.0700	14,383	10
11	Revenue Bonds 1991-C		x	Redeem Debt	$5,394.00	07/01/91	658,000	506,002	07/01/11	0.0775	36,229	11
12	Athens Athletic Assoc.		x	Apartments		07/01/78	123,500		07/01/03	0.0500	2,248	12
13												13
14	TOTAL Non-Facility Related				$5,394.00		$ 1,761,500	$ 597,669			$ 52,860	14
15	TOTALS (line 9+line14)						$ 5,060,700	$ 3,172,808			$ 245,808	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lewis Memorial Christian Village **#** 0021436 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	This W/P N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments
Congregate Living
Home Office

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	various	$ 308,762	1
2	Home Office			7,919	2
3	TOTALS	217,800		$ 316,681	3

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	$ 2,284,768	$ 56,112	40	$ 57,119	$ 1,007	$ 1,299,457	4
5				1978	100,542		40	2,514	2,514	57,822	5
6				1979	420,937		20			420,937	6
7											7
8	Home Office Allocation				56,509	1,846		1,846		24,534	8
	Improvement Type**										
9	Land Improvement			1977	70,709		20			70,709	9
10	Land Improvement			1978	15,161		20			15,161	10
11	Bldg Improvement			1979	306	6	38	8	2	126	11
12	Bldg Improvement			1979	2,062	54	38	54		1,161	12
13	Land Improvement			1979	23,654		20			23,654	13
14	Land Improvement			1979	5,572	85	20	85		5,572	14
15	Land Improvement			1980	521	26	20	26		520	15
16	Bldg Improvement			1981	4,662	155	30	155		2,920	16
17	Heating/Cooling Systems			1981	20,153	1,008	20	1,008		18,816	17
18	Exhaust Fan			1983	417		15			417	18
19	Land Improvement			1984	6,077	304	20	304		4,788	19
20	Door Assembly			1985	1,244	62	20	62		930	20
21	Land Improvement			1985	1,852	93	20	93		1,372	21
22	Crackfill Parking Lot			1986	1,860	124	15	124		1,746	22
23	Bldg Improvement			1986	573	29	20	29		411	23
24	Landscaping			1986	5,450	260	20	260		3,858	24
25	Pass-thru WD			1986	664	33	20	33		448	25
26	RD & Drainage			1986	3,236	162	20	162		2,200	26
27	Fire Hydrant			1987	2,600	130	20	130		1,679	27
28	Gravel Road			1987	250		10			250	28
29	Parking Lot			1987	4,249	212	20	212		2,756	29
30	Remodeling			1987	800	40	20	40		533	30
31	Rooftop Compressor			1988	3,408		10			3,408	31
32	Air System			1989	1,090	55	20	55		628	32
33	A/C Unit			1989	4,406		8			4,406	33
34	Remodeling			1989	6,193	310	20	310		3,513	34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,049,925	$ 61,106		$ 64,629	$ 3,523	$ 1,974,732	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Tile, Cover Base			1989	6,600		5			6,600	9
10	Wall Paper			1989	826	1	5	1		826	10
11	Water Softner			1989	3,475	232	15	232		2,649	11
12	Cabinets			1990	100	20	15	20		77	12
13	Parking Lot Resurface			1991	34,141		8			34,141	13
14	Roof Top A/C Unit			1991	4,158	416	10	416		3,744	14
15	Command Moduole			1991	1,318		5			1,318	15
16	Wall Paper/Carpet			1991	14,848		5			14,848	16
17	Drapery Hardware			1991	1,124		5			1,124	17
18	Carpeting			1992	640		5			640	18
19	Curtain Track			1992	523		5			523	19
20	Curtain Track			1992	4,124		5			4,124	20
21	Receptacle			1992	575	58	10	58		483	21
22	Curtain Track			1992	565		5			565	22
23	Curtain Track			1992	1,229		5			1,229	23
24	Fire Alarm			1992	621	31	20	31		235	24
25	Door Control			1993	722	48	15	48		360	25
26	Nurse Station Remodel			1993	28,351	1,418	20	1,418		10,329	26
27	Wallcoverings			1993	751	2	5	2		751	27
28	Fire Alarm			1993	658	33	20	33		234	28
29	Land Improvements			1993	1,564	156	10	156		1,105	29
30	Wallcoverings			1994	4,999		5			4,999	30
31	A/C Compressors			1994	1,506	151	10	151		1,044	31
32	Exhaust Fans			1994	2,183	146	15	146		1,010	32
33	Roof Entire Building			1993	125,670	8,378	15	8,378		55,613	33
34	Downspout Repairs			1994	6,000	400	15	400		2,600	34
35	Ceiling Tile			1994	1,149	115	10	115		738	35
36	TOTAL (lines 4 thru 35)				$ 248,420	$ 11,605		$ 11,605	$	$ 151,909	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wallpaper/Floor Covering			1994	8,787	2	5	2		8,787	9
10	Wallpaper/Floor Covering			1994	31,025		5			31,025	10
11	Wallpaper			1994	11,779	784	5	784		11,779	11
12	Lounge Remodel			1995	15,165	1,516	5	1,516		15,165	12
13	Volunteer Room Expansion			1995	6,796	680	10	680		3,549	13
14	Remodel Wing 100			1995	37,391	3,739	10	3,739		19,628	14
15	Remodel Shower Wing			1995	1,249	250	5	250		1,208	15
16	Wallcovering			1995	36,788	7,358	5	7,358		35,564	16
17	Enclosed Shelter			1995	3,700	370	10	370		1,727	17
18	Stainless Steel Floor Cooler			1996	1,873	375	5	375		1,625	18
19	Wanderguard Alzheimer			1996	10,455	1,046	10	1,046		4,281	19
20	Wallcovering			1996	3,910	782	5	782		3,258	20
21	Wallcovering			1996	13,073	2,615	5	2,615		10,242	21
22	Wallcovering			1997	31,504	6,301	5	6,301		22,054	22
23	Gas Meter & Lines			1997	7,378	1,476	5	1,476		4,920	23
24	Maglocks & Keypad			1997	7,194	719	10	719		2,397	24
25	Nurse Call System			1997	8,726	873	10	873		2,764	25
26	Resurface Parking Lot			1997	5,713	1,746	3	1,746		5,713	26
27	Wallcovering			1997	28,621	5,724	5	5,724		16,695	27
28	Exhaust Fan			1997	12,370	1,237	10	1,237		3,608	28
29	Upgro Energy Management System			1997	14,513	1,451	10	1,451		4,232	29
30	Upgro Antennae System			1997	2,400	480	5	480		1,360	30
31	Fire Alarm			1997	560	112	5	112		308	31
32	Hot Water Heater			1997	21,667	2,167	10	2,167		5,959	32
33	Wallcovering			1997	6,836	1,367	5	1,367		3,531	33
34	Fire Safety Gas Valve			1998	617	123	5	123		308	34
35	Locks			1998	782	156	5	156		377	35
36	TOTAL (lines 4 thru 35)				$ 330,872	$ 43,449		$ 43,449	$	$ 222,064	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wiring for Network			1998	625	125	5	125		281	9
10	Landscaping Courtyard			1998	5,134	1,027	5	1,027		2,140	10
11	Resurface Parking Lot			1998	11,034	3,678	3	3,678		7,256	11
12	Outlets for Kronos			1998	664	133	5	133		233	12
13	Entrance Canopy			1998	3,667	733	5	733		1,161	13
14	Fire Alarm Control Panel			1998	28,154	2,815	10	2,815		4,457	14
15	Repl Fire Alarm Device			1999	4,800	480	10	480		680	15
16	Kitchen Hood			1999	6,910	691	10	691		921	16
17	Fire Alarm Devices			1999	4,600	460	10	460		613	17
18	Garage			1999	44,246	1,106	40	1,106		1,659	18
19	Replace 8 Shower Valves			2000	10,084	1,681	5	1,681		1,681	19
20	Panduit Raceway			2000	13,130	985	10	985		985	20
21	Kitchen Ceiling			2000	5,923	197	10	197		197	21
22	Kitchen Walls			2000	2,099	18	10	18		18	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 141,070	$ 14,129		$ 14,129	$	$ 22,282	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 366,468	$ 40,276	$ 40,276	$	Various	$ 192,404	37
38	Current Year Purchases	81,172	3,572	3,572		Various	3,572	38
39	Fully Depreciated Assets	386,987					387,217	39
40	Home Office Allocation	49,324	5,091	5,091			40,105	40
41	TOTALS	$ 883,951	$ 48,939	$ 48,939	$		$ 623,298	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	1989 Ford Bus	1989	$ 38,359	$	$	$	5	$ 38,359	42
43	Patient Transport	1993 Chevy Pick-Up	1998	13,290	4,430	4,430		3	7,014	43
44										44
45	Home Office Allocation			10,741	2,296	2,296			3,311	45
46	TOTALS			$ 62,390	$ 6,726	$ 6,726	$		$ 48,684	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	5,033,309	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	185,954	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	189,477	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	3,523	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	3,042,969	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartment & Carport & Equip	$ 472,785	$ 15,167	$ 266,742	52
53	Duplex Bldg. & Land Improvement	3,835,470	151,637	841,620	53
54	Duplex Equip.	135,270	6,480	94,232	54
55	Congregate Bldg. & Land Improv.	3,345,733	84,202	835,895	55
56	Congregate Equip.	135,955	6,391	104,601	56
57	TOTALS	$ 7,925,213	$ 263,877	$ 2,143,090	57

G. Construction-in-Progress

	Description	Cost	
58	Construction in Progress	$ 631,619	58
59			59
60			60
61		$ 631,619	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ This W/P is not applicable.		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 682,076	$	1
2	Cash-Patient Deposits	11,937		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,351)	359,628		3
4	Supply Inventory (priced at FIFO)	17,665		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,519		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int Rec	5,901		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,079,726	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	308,762		13
14	Buildings, at Historical Cost	10,647,814		14
15	Leasehold Improvements, at Historical Cost	701,393		15
16	Equipment, at Historical Cost	1,176,052		16
17	Accumulated Depreciation (book methods)	(4,621,235)		17
18	Deferred Charges	18,051		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	919,298		21
22	Other Long-Term Assets (spe CIP	631,438		22
23	Other(specify): Contract Receivable	550,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,331,573	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,411,299	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 122,864	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,805		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	200,896		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,663		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 415,228	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,004,541		40
41	Bonds Payable	597,669		41
42	Deferred Compensation	1,258,234		42
	Other Long-Term Liabilities(specify):			
43	Apt/Resident Security Deposit	2,209,394		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,069,838	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,485,066	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,926,233	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,411,299	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,824,266	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,824,266	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,101,967	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,101,967	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,926,233	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,789,592	1
2	Discounts and Allowances for all Levels	(865,835)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,923,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,720	12
13	Barber and Beauty Care	33,732	13
14	Non-Patient Meals	632	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,260	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,344	23
	D. Non-Operating Revenue		
24	Contributions	521,802	24
25	Interest and Other Investment Income***	118,012	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 639,814	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential & Congregate	922,586	28
28a	Unrealized G/(L) on Sale of Equip & Investments	(8,478)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 914,108	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,519,023	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,030,445	31
32	Health Care	2,160,052	32
33	General Administration	907,192	33
	B. Capital Expense		
34	Ownership	428,479	34
	C. Ancillary Expense		
35	Special Cost Centers	803,676	35
36	Provider Participation Fee	87,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,417,056	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,101,967	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,101,967	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,755	1,887	$ 47,319	$ 25.08	1
2	Assistant Director of Nursing	1,764	1,897	39,335	20.74	2
3	Registered Nurses	13,092	14,078	278,148	19.76	3
4	Licensed Practical Nurses	30,686	32,996	502,674	15.23	4
5	Nurse Aides & Orderlies	99,532	107,024	1,040,697	9.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,578	1,697	14,536	8.57	9
10	Activity Assistants	1,911	2,055	16,158	7.86	10
11	Social Service Workers	10,561	11,356	84,494	7.44	11
12	Dietician					12
13	Food Service Supervisor	1,511	1,625	20,342	12.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,694	20,854	204,875	9.82	15
16	Dishwashers					16
17	Maintenance Workers	5,615	6,038	72,640	12.03	17
18	Housekeepers	19,063	20,498	137,769	6.72	18
19	Laundry	7,736	8,318	71,461	8.59	19
20	Administrator	3,050	3,280	89,005	27.14	20
21	Assistant Administrator					21
22	Other Administrative	5,011	5,388	55,833	10.36	22
23	Office Manager	1,874	2,015	26,310	13.06	23
24	Clerical	3,206	3,447	25,640	7.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	640	688	7,758	11.28	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	3,044	3,273	29,697	9.07	33
34	TOTAL (lines 1 - 33)	240,323	248,414	$ 2,764,691 *	$ 11.13	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	248	$ 9,728		35
36	Medical Director	5	320		36
37	Medical Records Consultant	30	992		37
38	Nurse Consultant				38
39	Pharmacist Consultant	114	2,141		39
40	Physical Therapy Consultant	114	6,795		40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	960		43
44	Activity Consultant				44
45	Social Service Consultant	48	3,694		45
46	Other(specify)	12	1,150		46
47					47
48					48
49	TOTAL (lines 35 - 48)	587	$ 25,780		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Florence	Administrator	0	$ 70,507
Mary Florence		0	2,478
Scott Hurley		0	20,772
Rachel Long		0	1,021
Marianna Taylor		0	1,326
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 96,104

B. Administrative - Other

Description	Amount
Management Fee	$ 214,236
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 214,236

C. Professional Services

Vendor/Payee	Type	Amount
Booth, Little & Antoline	Legal	$ 4,903
Van Ostrand & Elvidge Kelley	Legal	1,107
Cannon	Engineering	182
Cochran & Wilken	Engineering	728
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 6,920

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,880
Unemployment Compensation Insurance	16,380
FICA Taxes	203,824
Employee Health Insurance	82,814
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	10,544
Employee Physicals	5,649
Employee Uniforms	698
Related Party	(16,380)
Worker's Comp Medical Expense	2,494
Home Office Allocation	13,587
TOTAL (agree to Schedule V, line 22, col.8)	$ 382,490

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	6,133
Fees	1,005
Subscriptions	1,346
Promotion	284
Software Support	939
Home Office Allocation	1,206
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,913

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	772
Seminar Expense	2,498
Miscellaneous	573
Home Office Allocation	3,075
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,918

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA -$5,913**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,092** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,212**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **633**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **ECK, SCHAFER & PUNKE, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will mail when completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.